IMPERIAL FAMILY DENTAL CENTER

Financial and Appointment Policy

As a courtesy to our other patients, we kindly ask that you give a 48-hour notice if you require a change to your scheduled appointment.

Thank you for choosing Imperial Family Dental Center as your family's comprehensive dental healthcare provider. We want to provide you with the best service available. **To keep your dental cost as low as possible and help reduce our administrative costs, we do require payment at the time a dental service is provided to all family members. Our goal is to provide affordable dental services without unnecessary financial stress.**

Payment Options

1. **Cash/Check**. Please note that a $30.00 service fee will be charged to your account on all returned checks.
2. **Credit Cards**. For your convenience, we accept all major credit cards for payment.
3. **Insurance Co-Payment.** Our practice accepts dental insurance payments and is in-network with several insurance companies, please ask us about your plan. The total cost of your treatment is usually not covered by your dental insurance. As a courtesy, our office will file your insurance claim for you. We strive to have the latest insurance information to estimate the amount your insurance pays for the procedure(s); however, your insurance may determine payment differently than anticipated. Your insurance contract is between you, your employer, and the insurance company. We are not part of your contract. **Regardless of what we may calculate your insurance company to pay, it is only an estimate. We cannot guarantee what your insurance will pay and there may be a remaining balance owed by you**. I agree that I am responsible for all bills incurred by me at this office whether paid for by insurance or not. If there is a remaining balance left after you and your insurance have paid, we will send you a statement for the remaining balance. We also accept payment from out-of-network insurance companies. However, if your insurance provider chooses to reimburse you directly, you are responsible for payment in full at the time your dental treatment is provided. In addition, if your insurance provider fails to pay within 45-days after we submit your claim, you are responsible for the full cost (except those with Delta Dental).
   I authorize assignment of my insurance benefits (if applicable) directly to Imperial Family Dental Center and the use of electronic signature on all insurance submissions. I authorize Imperial Family Dental Center to release and/or request records to or from other providers as necessary. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

   I hereby authorize the Dentist to examine and treat my condition as he/she deems appropriate and I give authority for these procedures to be performed. The Dentist will not be held responsible for any pre-existing Dental conditions nor for any medical diagnosis.

We encourage you to keep in mind that we file your insurance as a courtesy to you and ultimately your balance at Imperial Family Dental Center is your financial responsibility.

The adult accompanying a minor is responsible for full payment. In the case of a divorce, the parent (or guardian of the minor) that brings the child in for dental treatment will be the responsible party regardless of legal arrangements. For unaccompanied minors, non-emergency treatment will be denied unless arrangements to pay the day of service by cash, check, or credit card have been made prior to the visit.

Should you need our services after-hours for emergency treatment, there will be a $150.00 fee in addition to any procedural costs incurred. This fee is not covered by insurance, and payment is due at the time of the after-hours visit.

A finance charge of 1.5% monthly will be charged on all accounts past 30 days. If your account requires servicing by a collection agency or by an attorney, you are liable for the collection fees, attorney fees, and applicable court costs, in addition to your outstanding balance.

By signing this form, you agree to the above conditions and fees along with authorizing the release of any dental information necessary to process your insurance claim and all future claims.

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Patient (or parent/guardian) Signature Date